

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

30089

State File No. \_\_\_\_\_

Registrar's No. 220

Registration District No. 151

Primary Registration District No. 3028

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Carthage  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
316 So. Fulton  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None  
Several years (Specify whether years, months or days)  
In this community

3. (a) PRINT FULL NAME Charles Green  
3. (b) If veteran, name war None  
3. (c) Social Security No. Unknown

4. Sex Male 0 5. Color or race White  
6. (a) Single, widowed, married, divorced Divorced  
6. (b) Name of husband or wife Unknown  
6. (c) Age of husband or wife if alive 10 years

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
About 68 --- -- hr. min.

9. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

10. Usual occupation General Laborer

11. Industry or business None

12. Name Unknown 9

13. Birthplace Unknown 1  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Rose Chaney

(b) Address 316 S. Fulton Carthage Mo.

17. (a) Burial (b) Date thereof 10/4/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cem. Joplin

18. (a) Signature of funeral director Hurlbut-Glover Mort

(b) Address 422 Sgt. Joplin, Mo.

19. (a) 10-4-1948 (b) L. B. Clinton  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 41  
(c) City or town Carthage  
(If outside city or town limits, write "RURAL.")  
(d) Street No. 316 S. Fulton  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29  
year 1948 hour 4 minute P.M.

21. I hereby certify that I attended the deceased from Sept. 18  
1948 to Sept. 26, 1948  
that I last saw him alive on Sept. 17, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral rupture Duration

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury.....

23. Signature E. B. B. B. (M. D. or other)

Address Joplin Mo. Date signed 10-7-48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

William E. Greer, Registered Apprentice No. 283  
working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 4593

P. O. Address Joplin, Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.